



**TEXAS DEPARTMENT OF HEALTH  
AUSTIN, TEXAS  
INTER-OFFICE MEMORANDUM**

**TO:** Herman Horn, Acting Chief, Bureau of Regional/Local Health Operations  
Regional Directors  
Directors, Local Health Departments  
Directors, Independent WIC Local Agencies

**FROM:** Gerald D. Cannaday, Jr. {original signed}  
Chief, Bureau of Nutrition Services

**DATE:** July 6, 2001

**SUBJECT:** Revised Supplemental Information Form (SIF), WIC 35-1

---

This memo is to notify you of changes to the Supplemental Information Form (SIF), WIC 35-1, and physical presence documentation. The revised form includes additional information regarding dual benefits, sharing information with other Special Supplemental Nutrition Program for Women, Infants and Children (WIC) programs when transferring, and documenting physical presence.

The Dual Benefits section has been added to ensure participants are aware of the possible consequences of receiving benefits from more than one clinic. Receiving dual benefits may subject participants to repaying in cash the value of food benefits improperly issued to them and/or their dependents, being prosecuted under State and Federal laws, or being disqualified from participating in WIC.

The Shared Client Information section now states that client information will be shared with other WIC programs when participants transfer. This will allow the release of client information as needed when they transfer.

The SIF will be used to document Physical Presence. Local Agency (LA) staff will document the physical presence of an applicant/participant on the SIF by checking the "Yes" or "No" box. If "Yes" is checked, the date the SIF is signed reflects the date the applicant/participant was physically present. If "No" is checked, a waiver will be completed and filed in the applicant/participant record.

An infant less than one month old may be allowed to be certified without being physically present if all required documentation is available. If this happens, check the "No" box. The infant must then be presented by his/her six-week birth date. Fill in the date the infant is physically presented in the "Date Infant Presented" box.

Effective July 20, 2001, the SIF shall be used to document Physical Presence. However, if the LA elects to develop its own local policy on the procedure that will be used to document the physical presence of an applicant/participant, the SIF shall not be used to document physical presence. The local policy must be specific and must be kept for an audit/review.

If you have questions or require additional information, please contact Ms. Karen Davis, Bureau of Nutrition Services, at (512) 406-0711, extension 221.

## Supplemental Information Form

- A. This agency will make health services and nutrition education available to you, and you are encouraged to participate in them.
- B. Standards for participation in the WIC program are the same for everyone regardless of sex, age, disability, race, color or national origin.
- C. I will buy only WIC approved foods and never redeem vouchers for cash, credit, non-food items or unauthorized foods.  
I will be polite to clinic and store staff. I understand that if I threaten or do harm to the staff, I may be suspended from the program.  
I will not sell or trade my WIC vouchers, food or formula purchased with WIC vouchers.  
I understand WIC foods are to be eaten by the WIC participant only.  
I understand that if my vouchers are lost or stolen, they may not be replaced.

### Dual Benefits

I hereby state that neither my dependents nor I currently receive benefits from another clinic. I also agree that I (we) will not receive WIC benefits from more than one clinic during the same time period. I understand that receiving dual benefits is considered fraud.

Receiving dual benefits may subject me to:

1. repaying in cash the value of food benefits improperly issued to me and/or my dependent(s)
2. prosecution under State and Federal laws, and
3. being disqualified from participating in WIC.

I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information provided to the WIC program. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under the State and Federal law. I am not participating in any other WIC Clinic.

### Shared Client Information:

The eligibility data used to enroll you in the WIC Program (income, medical information, etc.) will be shared with Health and Human Services Program or other WIC programs, if you transfer. The programs will use this information only to determine your eligibility for their program and will not release it to anyone else.

---

Signature of participant/parent/guardian/caregiver

Signature of additional parent/guardian/caregiver

Child's name

Physically Present  Yes  No

Date Infant Presented: \_\_\_\_\_

### I certify that I determined the eligibility of this participant

---

WIC Official Signature Title (must be a Competent Professional Authority)

Date

### Termination or Ineligibility Reasons(s) (Circle)

1. Moved out of state.
2. No condition of nutritional need:
  - Height, weight, and hemoglobin or hematocrit are within normal limits.
  - Diet is adequate.
  - Growth measurements are within normal limits.
  - Medical history shows no condition of nutritional need.
3. Exceeds income standard.
4. Child is five years old or older.
5. Pregnancy ended more than six months ago or mother stopped breastfeeding before one year or breastfed child is one year old.

6. Certification is past due.
7. Program abuse/dual participation. Program abuse includes, but is not limited to, the following:
  - Selling or trading WIC vouchers, food or formula purchased with WIC vouchers.
  - Threatening behavior or physical harm done to the clinic or store staff.
  - Failure to report correct income during certification.
  - Giving a false address during certification.
  - Receiving food vouchers from more than one WIC site.
  - Purchasing unauthorized foods with WIC food vouchers.
8. Caseload management. Please be advised that you or your child are still eligible for the program. You have been placed on a waiting list as a Priority.
9. Other \_\_\_\_\_

If found ineligible, you have been notified of the reason(s) for your ineligibility/termination and of the right to a fair hearing. If you feel your ineligibility was determined unfairly, you may request a fair hearing. The fair hearing procedure will be explained to you by personnel at this agency. You may also file a complaint by calling our toll-free number, 1-800-942-3678.

---

Signature of participant or parent/guardian/caregiver

Date

Child's name

### I certify that I determined the ineligibility of this participant

---

WIC Official Signature

Date

Title (If participant is ineligible due to reasons 2, 7, or 8, a Competent Professional Authority must sign.)



## Formulario De Información Suplementaria

- A. Esta agencia proporciona servicios de salud y educación nutricional y se le invita a participar.
- B. Las normas para participar en el programa WIC son iguales para todos, sin tomar en cuenta el sexo, la edad, incapacidad raza, color u origen nacional.
- C. Comprará solo los alimentos aprobados por WIC y nunca cambiaré los cupones por dinero, crédito, productos que no son comestibles o alimentos que no son autorizados.

Seré cortés con el personal de la clínica y la tienda. Entiendo que si amenazo o le causo algún daño al personal, se me puede suspender del programa.  
No venderé o cambiaré mis cupones de WIC, los alimentos o la fórmula comprados con esos cupones. Entiendo que los alimentos de WIC son para el uso del participante de WIC solamente.  
Entiendo que si pierdo mis cupones o me los roban, no se pueden reemplazar.

### Beneficios dobles

Declaro que en este momento, ni mis dependientes ni yo, estamos recibiendo beneficios de ninguna otra clínica. Además, estoy de acuerdo en que yo (nosotros) no recibiré (no recibiremos) beneficios de más de una clínica a la vez. Entiendo que esto se considera un fraude.

Al recibir beneficios dobles estoy propensa a:

1. pagar en efectivo el valor de los beneficios de alimentos que inapropiadamente se otorgaron a mi(s) dependiente(s) y a mí
2. ser juzada bajo las leyes estatales y federales,
3. ser descalificada para participar en WIC.

He sido advertido sobre mis derechos y deberes bajo este programa. Certifico que la información proporcionada para determinar si califico para recibir los servicios es correcta según my conocimiento. Este formulario de certificación se ha entregado en relación con el recibimiento de asistencia federal. Los oficiales del programa pueden verificar la información proporcionada al Programa WIC. Entiendo que hacer intencionalmente una declaración falsa o engañosa, o intencionalmente esconder, ocultar o distorsionar información puede resultar en un pago, en efectivo, a la agencia estatal por el costo de los beneficios alimenticios que se me otorgaron inapropiadamente, y puedo ser sometido a un tribunal en corte civil o criminal bajo las leyes federales y estatales. No estoy recibiendo servicios de ninguna otra clínica de WIC.

### Información que se comparte sobre el cliente:

La información que lo hace a usted elegible para el programa WIC (ingresos económicos, información médica, etc.), va a ser compartida con los programas de salud y servicios humanos anotados en la hoja anexa. Las agencias utilizarán la información con el único propósito de determinar su elegibilidad para sus programas, y no únicamente proporcionará a nadie más.

Firma del participante/padres/tutor/persona que los cuida

Firma adicional padres/tutor/persona que los cuida

Nombre del niño

Presente en persona  Sí  No

Fecha en que se presentó el bebé: \_\_\_\_\_

### Certifico que he determinado la elegibilidad de este participante

Firma del oficial de WIC Título (debe ser una Autoridad Professional y Competente)

Fecha

### Razones por terminación de servicios o inelegibilidad (Ponga un círculo)

1. Se mudó para otro estado.
2. No se muestran deficiencias nutricionales:
  - Estatura, peso, hemoglobina, "hematocrit", están dentro de los límites normales.
  - Dieta adecuada.
  - Desarrollo dentro de los límites normales.
  - La historia clínica no muestra una condición de necesidades nutricionales.
3. Sobre pasa los límites de ingresos económicos.
4. El niño tiene cinco años o más.
5. El embarazo terminó hace más de seis meses, ro la madre dejó de alimentar con pecho al niño antes del primer año, o el niño alimentado con pecho tiene más de un año.
6. Se venció la certificación .

Si se determina que es inelegible, usted ha sido notificado de las causas de la inelegibilidad/terminación, y de su derecho en pedir una audiencia justa. Si usted piensa que fue declarada inelegible fuera de su derecho, usted puede solicitar una audiencia justa. La audiencia justa le será explicada a usted por el personal de esta agencia. También puede dar su queja llamando a la línea gratuita al 1-800-942-3678.

Firma de participante/padres/tutor/persona que lo cuida

fecha

Nombre del niño

### Certifico que he determinado la inelegibilidad de este participante

Firma del Oficial de WIC

Fecha

Título (Si el participante es inelegible por las razones 2, 7, or 8 a una persona que firma debe ser una Autoridad Professional y Competente)

